Re: Medical Dispute Resolution
MDR #: M2-02-0842-01
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating physician. Your case was reviewed by a physician reviewer who is Board Certified in Anesthesiology.

THE PHYSICIAN REVIEWER OF YOUR CASE **AGREES** WITH THE DETERMINATION MADE BY THE UTILIZATION REVIEW AGENT ON THIS CASE. THE REQUESTED 20 DAY, 8 HOUR PER DAY, MULTIDISCIPLINARY PAIN MANAGEMENT PROGRAM IS NOT MEDICALLY NECESSARY.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on July 29, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for___, ___. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0842-01, in the area of Anesthesiology and Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of a 20-day multi-disciplinary pain management program.
2. Correspondence.
3. Histories and physicals and office notes, dated 2002.
4. History and physical and office notes, dated 2001.
5. Progress notes.
6. Procedure notes.
7. Functional capacity evaluations.
8. Radiology reports.

B. BRIEF CLINICAL HISTORY:

The patient is now a 20-year-old female who experienced an apparent work-related lumbar spinal/sacral injury on ___. She had the onset of lower back pain. Extensive studies and evaluations have subsequently noted continued pain complaints but little or no specific findings suggesting an ongoing specific injury. An MRI exam reported only small disk bulges at L4-5 and L5-S1 without neurologic compression. The patient's complaints have extended to the upper extremities, the upper back, and the neck.

The patient has been variably treated with epidural steroid injections, facet injections, and trigger point injections. The patient has had trials of physical therapy, electrical stimulation, behavior modification, and work hardening therapy. The patient has variably been treated with antidepressants, narcotics, muscle relaxants, and sedatives without improvement. No modality has provided any significant improvement.

The record repeatedly references poor compliance and concerns about prescription drug usage. The findings on history are variably noted as being inconsistent, and the patient's activities are noted as being inconsistent with the complaints. The request for a 20-day multi-discipinary pain program follows this history.

C. DISPUTED SERVICES:

A 20-day multi-discipinary pain management program.

D. DECISION:

I AGREE WITH THE ___ ADVERSE DETERMINATION FOR THE DISPUTED SERVICE.

E. RATIONALE OR BASIS FOR DECISION:

The patient's original injury appears to have been a lumbar/sacral "sprain," in light of the negative physical exams and MRI studies. No definable injury is elicited by any exam or study, save a single EMG study. The patient does have a complex chronic pain syndrome without any clear relationship to the injury. The patient's complaints of pain, both regard to severity and physical location, are inconsistent and out of proportion to any documented injury. A poor outcome for the proposed therapy is predicted by a history of poor therapy compliance, personal activities inconsistent with the level of reported pain, the failure of aggressive prior modalities, and the lack of any objective physical impairment secondary to

the chronic pain syndrome. The diligence and commitment to assist this patient are notable in all of this patient's providers.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

_____

Date: 28 July 2002